Metacognitive narrative psychotherapy for people with schizophrenia: An outline of a principle-based treatment manual

Rebecca Bargenquast

Robert Schweitzer

School of Psychology & Counselling, Queensland University of Technology, Australia

Address Correspondence to

Associate Professor Robert Schweitzer

School of Psychology and Counselling

Queensland University of Technology

Kelvin Grove QLD 4059

Australia

Email: r.schweitzer@qut.edu.au

Metacognitive narrative psychotherapy for people with schizophrenia: An outline of a principle-based treatment manual

The paper aims to outline a psychotherapeutic treatment model, Metacognitive Narrative Psychotherapy, for people diagnosed with schizophrenia with application in treatment and research settings. It is widely acknowledged that the core pathology of schizophrenia is a disturbance in sense-of-self and consequently impoverished self-experience (Davidson, 2003; Roe & Ben-Yishai, 1999; Sass & Parnas, 2003). Despite this, current treatment options tend to neglect subjective aspects of the disorder and instead focus solely on symptom reduction, with first-line treatment usually being anti-psychotic medication. However, growing interest in the phenomenology of schizophrenia and recovery from severe mental illness has seen the development of innovative interventions that aim to enhance sufferers' experiences of themselves as active agents in the world (Davidson, 2003; Nelson, Yung, Bechdolf, & McGorry, 2008).

Metacognitive Narrative Psychotherapy, drawing upon dialogical narrative understandings of self and psychosis, has been articulated by Lysaker, Lysaker and Lysaker (2001). Adopting a dialogical narrative approach to understanding self-experience, Lysaker and colleagues argue that self-experience in people with schizophrenia can be enhanced by improving capacity for metacognition and ability to develop a coherent life narrative (Lysaker, Glynn, Wilkniss, & Silverstein, 2010). Case-study evidence suggests a dialogical approach to psychotherapy with people with schizophrenia leads to improvements in metacognitive capacity and narrative coherence, increased independence, improved relationships, and a reduction in positive

and negative symptoms (Lysaker, Buck, & Ringer, 2007; Lysaker, Davis, et al., 2005; Lysaker, Davis, Jones, Strasburger, & Beattie, 2007; Lysaker & Gumley, 2010). Despite these promising findings, there are currently no systematic guides to enable the implementation of this approach in a standardised manner that can be replicated for clinical and research purposes.

Dialogical narrative approaches to psychotherapy are founded upon postmodern conceptualisations of truth and the self. In contrast to modern psychiatry, postmodernist ideology reject notions of objective truth that can be discovered and measured. Rather, postmodernists assert that notions of truth are constructed by individuals interacting with their environment, and therefore are dependent on context (Gergen, 1985; Roberts, 2000). According to narrative approaches, construction of meaning is a dialogical process whereby relationships between the author of the narrative and the real or imagined audience facilitates the emergence of new meaning (Hermans, Rijks, & Kempen, 1993). Dialogical narrative conceptualisations of the self also reject the notion of a "core self" and instead conceive of the self as relational and ever-changing. Postmodernists argue that a "healthy" self comprise internal dialogues among complementary, competing, and at times, contradictory self-positions" (France & Uhlin, 2006, p. 58).

A postmodern approach to understanding truth and the self poses some specific challenges for developing a psychotherapeutic intervention.,Unlike symptom-focused approaches such as cognitive-behavioural therapy, it is antithetical to narrative approaches to prescribe interventions (Pote, Stratton, Cottrell, Shapiro, & Boston, 2003). Therefore, postmodern therapies are rarely manualised for the purpose of research.Nevertheless , a narrative approach has previously been operationalised by Vromans (2007) for the treatment of depression. Vromans' (2007) manualised narrative

approach recognised and managed the tension between modern and postmodern frameworks by specifying an approach that was able to be standardised across research therapists, but also offered a level of flexibility that upheld postmodern ideology and allowed both therapist and client to contribute to the therapeutic process.

Drawing upon Vromans (2007) operationalisation of narrative therapy, Metacognitive Narrative Psychotherapy for people with schizophrenia integrates narrative understandings of truth and the self with the research findings of Lysaker and colleagues. The current paper describes narrative conceptualisations of schizophrenia and the development of a principle-based manual for Metacognitive Narrative Psychotherapy for the treatment of people with schizophrenia. Five general phases of treatment, including prescriptive principles and proscribed practices, are identified and described.

Understanding schizophrenia in metacognitive narrative psychotherapy

Current treatment options aim to reduce the impact of objective, symptomatic manifestations of the disorder and often dismiss sufferers' subjective distress. Unlike current treatment options, Metacognitive Narrative Psychotherapy focuses on client's subjectivity; symptom reduction is not a primary aim but may be a secondary outcome. As articulated by Lysaker, Lysaker, and Lysaker (2001), the fundamental dysfunction of schizophrenia is a collapse of the dialogical self, resulting in profound disturbances in the construction and development of personal narratives, metacognitive functioning, and intersubjectivity. These areas of disturbance significantly impact self-experience in people with schizophrenia and form targets for intervention in Metacognitive Narrative Psychotherapy.

Narratives of people suffering with schizophrenia often lack coherence, fail to portray the author as the story's protagonist, and appear meaningless to listeners (Davidson & Strauss, 1992). According to dialogical theory of self, impoverished self-experience found in people with schizophrenia is due to a disturbance in processes that allow individuals to move smoothly among self-positions, resulting in three possible types of narrative impoverishment: barren, cacophonous, and monological (Lysaker & Lysaker, 2006). *Barren self* is characterised by a limited number of self-positions or self-positions that cease to dialogue meaningfully. *Cacophonous self* is made up of multiple self-positions that lack guided interaction, dialogical hierarchy, and socially validated coherence. *Monological self* is rigidly governed by one or two voices, which leads to an inflexible monologue.

Impaired metacognition has been linked to difficulties in developing meaning from experiences, severity of delusions, poor insight, trouble constructing coherent and meaningful narratives, and diminished sense-of-self (Harrington, Langdon, Siegert, & McClure, 2005; Lysaker, Carcione, et al., 2005). The loss of sense-of-self experienced by people with schizophrenia not only leads to impaired first-person awareness, but also impaired second-person awareness. Metacognitive Narrative Psychotherapy aims to enhance client's awareness and understanding of the first- and second-person – the subjective and intersubjective.

Development of a principle-based manual

Methodology

The development of the manual was largely informed by an in-depth literature review which examined

1. Dialogical theory of self and the work of Lysaker and colleagues (e.g. Hermans, et al., 1993; Lysaker, et al., 2011; Lysaker & Lysaker, 2006);
2. Postmodern and narrative theory and principles of psychotherapy (e.g. Anderson, 1997; Angus & McLeod, 2004; McLeod, 2004; White & Epston, 1990), and Vromans' (2007) operationalisation of narrative therapy for depression.
3. General principles of the psychotherapy of schizophrenia (e.g. Fenton, 2000).

Literature reviewed included case-study evidence, clinical acumen from experts, and in-depth qualitative investigations of therapeutic processes.

Specific principles and broad therapy processes were identified for five general phases of treatment: (1) Developing a therapeutic relationship; (2) Eliciting narratives; (3) Enhancing metacognitive capacity*;* (4) Enriching narratives; (5) Living enriched narratives. Proscribed practices were also identified. Strategies for applying the principles, including examples, were also developed. To allow for therapeutic flexibility and therapist-client collaboration linear session-by-session instructions were not included.

The manual was reviewed by an expert panel, comprising Associate Professor Lysaker, Associate Professor Schweitzer, and Dr. Vromans. Feedback was used to revise and finalise the manual, titled *Metacognitive Narrative Psychotherapy for People with Schizophrenia: Guiding Principles and Practices*.

Treatment model

Metacognitive Narrative Psychotherapy is an integrative approach drawing upon principles informing narrative approaches to therapy and recent research investigating metacognitive narrative approaches for schizophrenia. It involves individual therapy sessions in which the client is provided with a supportive environment that enables reflection; encourages the exploration of strengths and difficulties; and assists in the making of connections between the past, present, and future. The intervention complements pre-existing practices and addresses a gap in current treatment options for people with schizophrenia, in that, it focuses on disturbance of self-experience by targeting deficits in capacities for metacognition and coherent storytelling. While each phase of treatment consists of specific treatment goals and techniques, sessions are not conducted in a prescriptive or rigid manner. Rather, the psychotherapy process is unpredictable, non-linear, and unique for each individual. It is not a time-limited approach, with improvements often being followed by setbacks, which are then followed by further progress.

Treatment Fidelity

A treatment adherence scale was developed (see Appendix). The *Metacognitive Narrative Psychotherapy Integrity Schedule* consists of 18 items and is intended to quantitatively measure the degree to which therapists adhere to the manual and are competent in implementing the approach. It may be used by independent raters or therapists to assess their own therapy integrity. The structure of the schedule is based upon the Narrative Therapy Adherence Schedule (N-TIS; Vromans, 2007). The first 15 items represent principles from each of the five treatment phases and can be scored as true, partially true, or false (True = 1; Partially True = 0.5; False = 0). The final three

items represent principles from the proscribed practices and can be scored as either true or false (True = 0; False = 1).

Metacognitive Narrative Psychotherapy for people with schizophrenia

Phase 1: Developing a therapeutic relationship

The first phase of Metacognitive Narrative Psychotherapy focuses on the development and maintenance of the therapeutic relationship. A shared partnership between therapist and client forms the foundation for effective interventions and can be achieved through the adoption of a curious, non-authoritarian therapeutic stance, therapist tolerance of confusion and uncertainty, therapist awareness of countertransference, and in-session focus on the therapeutic relationship.

A shared partnership is created when meaning and understanding emerge as a result of a negotiation between the subjective experiences of the therapist and the subjective experiences of the client (Stanghellini & Lysaker, 2007). For this to occur a dialogical space – a metaphorical space that exists between and within the therapist and the client – must be created (Anderson, 1997). This space provides room for the therapist and client to entertain multiple ideas, beliefs, and opinions. The development of a dialogical space is assisted by the adoption of a curious, "not knowing" therapeutic stance. "Knowing – the delusion of understanding or the security of methodology – decreases the possibility of seeing and increases our deafness to the unexpected, the unsaid, and the not-yet-said" (Anderson, 1997, p. 134). The client is regarded as an expert about their own life experiences and their subjectivity is privileged. The therapist prioritises empathic attunement and rapport over fixing the client's apparent deficits (Nelson & Sass, 2009). The therapist's ability to be comfortable with confusion and uncertainty without "doing" or "fixing" gives the client the space to make sense of their

experiences without excessive interference from the therapist. For example, client's voice-hearing and unusual beliefs – experiences characteristic of schizophrenia spectrum disorders – are considered to be meaningful and often rational given the client's history and current context (Harper, 2004; Roberts, 1991). The therapist adopts a non-pathologising approach to voice-hearing and unusual beliefs, which considers the functional purpose of these experiences and focuses on their meaning and biographical context, rather than on their truth status.

The therapist also acknowledges the interpersonal nature of psychotherapy, and as such "deals" with the therapeutic relationship. This often involves focusing on the relationship and facilitating the narration of what is going on within it. This process allows the client and therapist to make meaning of their relationship. The process also involves addressing misunderstandings or ruptures. People suffering with schizophrenia are often extremely sensitive to failings in empathic listening; mistrustful of others; struggle with an overwhelming need for closeness; and experience difficulty differentiating their own thoughts, feelings, and impulses from those of others; all of which increase the likelihood of therapeutic ruptures (Fenton, 2000; Fromm-Reichmann, 1954; Wasylenki, 1992). When ruptures occur the therapist explores them openly and non-defensively, with effective exploration of alliance ruptures often leading to progress in therapy (Safran & Muran, 2000).

Finally, to facilitate the development and maintenance of the therapeutic relationship, the therapist is aware of their countertransference. Therapist's working with people with schizophrenia often experience intense countertransference reactions of anger, despair, hopelessness, and frustration; reactions that often mirror the inner experiences of the person with schizophrenia. Therefore, the therapist is aware of their own reactions and feelings during sessions, as this information often provides a glimpse

into the world of the client. Further, therapists' awareness of, and reflection upon, their own experiences during sessions minimises the harmful impact of countertransference on the therapeutic process and relationship.

Phase 2: Eliciting narratives

Phase Two of treatment aims to establish dialogue with the client and elicit narrative episodes. Interventions are designed to target the three different types of narrative impoverishment described by Lysaker and Lysaker (2002, 2006): barren, monological, and cacophonous. In the case of a barren narrative, the therapist encourages the client to start thinking of themselves as someone who has experiences and stories to tell. This is done by exploring and expanding upon story fragments expressed by the client. For example, in-session a client reported a fragment of self-experience stating that he caught a bus to therapy. His therapist used open questions ("What bus did you catch?"; "How often do you use buses to get around?") to facilitate the expansion of the client's experience. The therapist also enhances the client's awareness of themselves as storyteller by encouraging their narration of their experience in-session ("What has today's session been like for you so far?").

When presented with a monological narrative, the therapist targets the client's inability to engage in dialogue rather than the content of their stories. This is done by recognising and reflecting upon, how certain thoughts make it impossible for the client to think of anything else ("At the moment it is hard for you to think of anything else other than X"). By offering the client empathic reflections, the therapist avoids agreeing or disagreeing with an unusual belief and in turn creates space for dialogue. The therapist may also focus on the second-person experience by reflecting upon the meaning or affect that underlies an unusual belief. For example, in response to a client's

persecutory ideation his therapist responded: “It’s hard for *you* to trust people” and “The world seems like an unsafe place for *you*”.

In the case of the cacophonous narrative the therapist is encouraged to avoid imposing their own meanings on the chaos (Lysaker & Lysaker, 2006). Instead dialogue between therapist and client is established through the therapist’s recognition and support of fragments of self-positions as they arise. This can simply be done by reflecting or mirroring the tangible, reality-oriented pieces of whatever the client reveals.

Phase 3: Enhancing metacognitive capacity

Once dialogue has been established, Phase Three specifically targets deficits in metacognitive capacity, drawing upon the work of Semerari and colleagues’ (2003) and Lysaker, Buck, and colleagues (2011). Improvements in capacity for metacognition lead to an increased ability to narrate one’s experiences, and as such a more complex, coherent sense-of-self. Metacognitive capacity refers to the ability to think about one’s own and others’ thoughts and feelings, and involves a series of acts, each with increasing complexity. For example, understanding one’s own mind involves: distinguishing one’s cognitive operations, distinguishing one’s emotions, knowing one’s thoughts are subjective and fallible, knowing “reality” may be different from what one desires (Lysaker, et al., 2011). Interventions aim to stimulate self-reflection and may involve reflecting upon the self-reflective function the person is engaging in (“You are remembering X”) or challenging them to think about their or other’s thinking and feelings in a more complex manner (“What was that like for *you?”*; “How do you think that made X feel?”). The therapist models a reflective, questioning stance and as such creates a space in which the client’s internal experiences can be openly thought about.

Therapists determine the level of metacognition clients are capable of performing, and as such offer interventions appropriate to that level. For example, a client who is able to define and distinguish their own cognitive operations may struggle to reflect upon their own emotional states. Therefore, an in-session focus on affect ("How do you feel about this?") may be inappropriate as it requires the client to do something that is beyond their current metacognitive capabilities. A client's capacity for metacognition may vary from session to session, with improvements often being followed by regressions, which are then followed by further progress. Notably, a client's ability to make sense of their own internal experiences often needs to be promoted before their ability to understand others' minds can develop (Dimaggio, Lysaker, Carcione, Nicolò, & Semerari, 2008).

Phase 4: Enriching narratives

Phase Four aims to facilitate the discovery of forgotten, quietened, or undeveloped self-positions and enrich clients' self-experience through developing complexity in their narratives. A rich life narrative includes stories about strengths, hopes, dreams, difficulties and losses. When any of these stories are neglected, the person's ability to make sense of who they are both inside and outside of their illness is compromised (Griffin, 1992). People with schizophrenia often tell stories in which they fail to portray themselves as protagonists who have the ability to act and affect their life course. They may also become consumed by the "sick role", where they see themselves as nothing more than "schizophrenic", "unwell", or "disordered". Experiences such as these contribute to the diminished sense-of-self, lack of effective agency, depression, and hopelessness experienced by many people with schizophrenia. Therefore, the dialogical exploration of the client's first-person experience and the simultaneous construction of

them as agent-protagonist in the stories they tell is an important part of Metacognitive Narrative Psychotherapy.

During this phase, the therapist encourages the client to think of themselves as someone *in* the story they are telling and explores the client's first-person experience by emphasising the second person in their reflections and questions ("*You* heard ..."; "What was that like for *you*?"; "How did *you* feel when that happened?"). The therapist also offers reflections about the presence of the client as a protagonist in the stories they tell ("You decided to call your mother for the first time in months, and ended up talking to her for an hour"), and explores links between the client's actions and changes in their self-experience ("After speaking to your mother, you felt 'less anxious' and 'more in control'"; "You had been avoiding this for a long time... so how did you end up doing it?").

The exploration of aspects self outside of "illness" is also an important part of Phase Four. Aspects of self outside of illness may be related to hobbies and interests, employment, or relationships with others. The exploration of stories outside of illness does not disregard the client's distress and difficulties or simply put a "positive spin" on their experiences. Instead, stories outside of illness are seen to sit alongside stories of distress and suffering. They are not constructed to replace or eradicate stories of illness, but rather stories outside of illness disempower stories of illness, enriching the person's life narrative. The continued exploration of the person's capabilities and aspects of self outside of their illness makes space for envisioning the future while continuing to grieve past losses and process negative affects linked with the past ("In the past you have felt fearful of being close to others, but now you are speaking of your desire to have a relationship in the future. Tell me more about this change?").

Phase 5: Living enriched narratives

The final phase of Metacognitive Narrative Psychotherapy focuses on generalising gains made during therapy to clients' everyday life. During previous phases of treatment, clients have developed an enriched life narrative and rediscovered important aspects of their self-experience. An enhanced sense-of-self opens the possibility of adopting new ways of being or acting, which includes being an agent-protagonist of one's own life. Clients are encouraged to "live" their enriched life narrative in situations outside of the therapy session, with their story becoming an element of interpersonal relationships other than the therapeutic relationship ("Given that 'opening up' has helped you feel connected to me during our sessions, how might 'opening up' help you feel closer to other people in your life?").

Phase Five also involves processing the end of therapy, which often represents a loss for the client. Time needs to be taken in-session to explore the impact of termination. This may involve processing painful affect such as anger, sadness, and guilt, and past experiences of loss and abandonment evoked for clients in response to ending therapy. The importance of this phase cannot be over emphasised.

Proscribed Practices

In practicing Metacognitive Narrative Psychotherapy the therapist should not assume an authoritarian, rigid, or secretive stance in relation to how they engage with clients. The therapist is reminded to be transparent about the ways in which they work. Further, they should not label clients, as labels limit possibilities and hinder the development of a rich life narrative. The therapist is encouraged to be curious about the client's understandings of their difficulties and experiences. The therapist should also avoid telling or "fixing" clients' stories. The meaning they derive from clients' narratives may

be valid, but by imposing their view onto clients they deprive them of the opportunity to be their own storyteller, which ultimately sustains their narrative disruption. Similarly, the therapists should not positively reframe or suggest positives. It is important that clients assign their own meaning to their experiences and are given the opportunity to discover their own strengths and "positives" in their life (Vromans, 2007).

Most importantly, the therapist should not facilitate too much or too rapid uncovering and self-disclosure. For people with schizophrenia the rapid gain of insight can result in decompensation and the development of depression, hopelessness, anxiety, and suicidal ideation and intent (Martens, 2009). The aim of a metacognitive narrative approach to therapy is not to excavate and dissect the past. Similarly, free association – the spontaneous, logically unrestrained and undirected association of ideas, wishes, needs, and feelings – should not be encouraged as it may aggravate disorganisation and thought disorder (Fenton, 2000). Finally, the intensity of the interpersonal engagement in therapy sessions should be guided by clients. Developing a close connection with another person can be a challenging, anxiety-provoking process. Therefore, the therapist should not let their own desire to connect with clients overshadow clients' needs.

Discussion and Conclusions

The current paper articulates a manualised treatment approach based upon dialogical narrative principles of psychotherapy addressing the needs of people with schizophrenia spectrum disorders. Translating a psychotherapeutic approach into a form that can be easily disseminated poses a number of challenges. This is made particularly complex as processes of change within psychotherapy are multifaceted and often determined by client characteristics, therapist characteristics, characteristics of the client-therapist dyad, and therapy technique. The treatment manual, *Metacognitive Narrative*

Psychotherapy for People with Schizophrenia: Guiding Principles and Practices, articulates specific therapeutic techniques, broad therapeutic processes, and features of an optimal therapeutic relationship, to inform an approach to the treatment of people with schizophrenia focusing on subjective distress and self-experiences. To date a number of therapists have been trained in the manualised treatment approach outlined. Preliminary evidence suggests that therapists are able to achieve fidelity with the approach and apply it in the treatment of people with schizophrenia. Reports from therapists trained in the approach suggest both strengths and limitations to a principle-based manual. The avoidance of linear session-by-session instructions within the manual offers therapists flexibility in applying the therapeutic techniques. However, it also means therapists are required to adopt a less structured, less directive approach than other manualised treatments (e.g. CBT), which can be anxiety-provoking, particularly when working with a complex population. Due to the flexible nature of the manual's structure, its application is best supported with ongoing supervision.

The psychotherapeutic principles as outlined above have been implemented in a pilot treatment study of people with schizophrenia, which has spanned over twelve to eighteen months. Initial findings demonstrate the utility of this approach and its acceptance among clients who have suffered with schizophrenia for five to twenty-five years. Dropout rates have been exceptionally low. Initial evidence also suggests positive treatment outcomes, with findings reported elsewhere. It is hoped that further research utilising these principles will demonstrate the effectiveness of a psychotherapeutic approach to treatment for a group of clients whose psychological needs and subjective distress have not been well attended to.

Appendix **745**
Metacognitive Narrative Psychotherapy Integrity Scale

Guidelines for Rating Therapy Sessions

Items for *Phases 1 – 5* should be endorsed as true, partially true, or false (True = 1; Partially True = 0.5; False = 0). Items should be endorsed as "Partially True" if the therapist meets the criteria sometimes during the session but fails to adhere at other times. While *Proscribed Practice* items should be endorsed as either true or false (True = 0; False = 1). If an item is not applicable to a therapy session raters should mark the item as "Not Applicable" (N/A). For example, where therapy is in the initial phases, the items referring to "Living Enriched Stories" may not be applicable, in which case N/A should be endorsed. To assist in the rating process, each item is followed by a list of the relevant sections in the manual.

Phase 1 Adherence Items – Developing a Therapeutic Relationship

Verbal and non-verbal communication reflected an equal and collaborative therapeutic relationship (e.g. appropriate body language/tone of voice, the use of non-formal language, appropriate room setting).

The therapist prioritised empathic attunement over "fixing up" the person's difficulties (e.g. actively listened, appropriate use of encouragers, appropriate use of silence, offered appropriate reflections of content/feelings/meaning).

The person was regarded an expert about their own life experiences and their subjectivity was privileged (e.g. a "not knowing", curious therapeutic stance was adopted).

If necessary, the therapist "dealt" with the therapeutic relationship and process (e.g. the therapist was interpersonally available and willing to discuss the therapeutic relationship with the person-in-therapy; the therapist explored the person's experience of the therapy session – *"How has today's session been for you?"*).

Phase 2 Adherence Items – Eliciting the Person's Narratives

The therapist used appropriate interventions – questions, reflections, observations – to elicit a narrative episode (e.g. what/when/where/who) and facilitate the person's storytelling (e.g. a here-and-now focus may be necessary to help a person to discuss their experiences: *"I've noticed that you are fidgeting more than usual today").*

The therapist used the words and terms expressed by the person when discussing the person's difficulties, and asked them to explain the meaning of salient terms (e.g. *"When you say felt trapped, what do you mean?"*)

The therapist noticed and reflected upon recurring self-positions expressed by the person-in-therapy (this may include reflecting upon expressed affect).

Phase 3 Adherence Items – Enhancing Capacities for Metacognition**

The therapist used interventions – questions and reflections – consistent with the person's capacity for self-reflection and ability to understand their own mind in the moment.

The therapist used interventions – questions and reflections – consistent with the person's capacity for empathy and ability to understand others' minds in the moment.

***These items assess the therapist's use of appropriate reflections and questions, and their ability to adjust interventions according to the person's response (e.g. If the person struggles to make use of a particular question [How did that make you feel?], the therapist intervenes in a different way rather than continuing to ask similar questions).*

Phase 4 Adherence Items – Enriching the Person's Narratives

The therapist used interventions that emphasised the second-person (e.g. "*You* heard"; What was that like for *you*?"; "How did *you* feel when that happened?").

Exploration of the person's experiences was multilayered, i.e. the therapist enquired about actions, thoughts, feelings, and physiological sensations (i.e. assess the therapist's use of open and closed questions).

The therapist applied interventions that acknowledged and explored the presence (or lack) of the person as a protagonist (active agent) in the stories they told.

The therapist assisted the person to make links across contexts and time (past, present, and future).

Phase 5 Adherence Items – Living Enriched Stories

The therapist assisted the person to recognise and explore new possibilities for his or her life.

The therapist openly explored issues related to termination.

Proscribed Practices Adherence Items

The therapist labelled or diagnosed the person or focused on the person's deficits (This does not include listening to the person's difficulties/distress).

The story being told was deemed to be the problem (e.g. the therapist filled in the "gaps" of a chaotic, incoherent narrative; colluded with or challenged unusual beliefs; told the person's story for them or tried to "fix" their story by using psychological theories to create meaning instead of prioritising the person's narrative).

The therapist directed or provided the person with advice concerning problems (This does not include negotiating with the person preferred ways of acting, e.g. making tentative suggestions).

References

Anderson, H. (1997). *Conversation, language, and possibilities: A postmodern approach to therapy*. New York: BasicBooks.

Angus, L. E., & McLeod, J. (2004). Self-multiplicity and narrative expression in psychotherapy. In H. J. M. Hermans & G. Dimaggio (Eds.), *The Dialogical Self in Psychotherapy* (pp. 77-90). East Sussex: Brunner-Routledge.

Davidson, L. (2003). *Living outside mental illness: Qualitative studies of recovery in schizophrenia*. New York: New York University Press.

Davidson, L., & Strauss, J. S. (1992). Sense of self in recovery from severe mental illness. *British Journal of Medical Psychology, 65*, 131-145.

Dimaggio, G., Lysaker, P. H., Carcione, A., Nicolò, G., & Semerari, A. (2008). Know yourself and you shall know the other... to a certain extent: Multiple paths of influence of self-reflection on mindreading. *Consciousness and Cognition, 17*(3), 778-789. doi: 10.1016/j.concog.2008.02.005

Fenton, W. S. (2000). Evolving perspectives on individual psychotherapy for schizophrenia. *Schizophrenia Bulletin, 26*(1), 47-72.

France, C. M., & Uhlin, B. D. (2006). Narrative as an outcome domain in psychosis. *Psychology and Psychotherapy: Theory, Research and Practice, 79*(1), 53-67.

Frith, C. D. (1992). *The cognitive neuropsychology of schizophrenia*. Sussex, England: Lawrence Erlbaum Associates.

Fromm-Reichmann, F. (1954). The academic lecture: Psychotherapy of schizophrenia. *Am J Psychiatry, 111*(6), 410-419. doi: 10.1176/appi.ajp.111.6.410

Gergen, K. J. (1985). The social constructionist movement in modern psychology. *American Psychologist, 40*(3), 266-275.

Griffin, S. (1992). *A chorus of stones: The private life of war*. New York: Doubleday.

Harper, D. J. (2004). Delusions and discourse: Moving beyond the constraints of the modernist paradigm. *Philosophy, Psychiatry, and Psychology, 11*(1), 55-64. doi: 10.1353/ppp.2004.0041

Harrington, L., Langdon, R., Siegert, R., & McClure, J. (2005). Schizophrenia, theory of mind, and persecutory delusions. *Cognitive Neuropsychiatry, 10*(2), 87 - 104.

Hermans, H. J. M., Rijks, T. I., & Kempen, H. J. G. (1993). Imaginal dialogues in the self: Theory and method. *Journal of Personality, 61*(2), 207-236.

Lysaker, P. H., Buck, K. D., Carcione, A., Procacci, M., Salvatore, G., Nicolò, G., et al. (2011). Addressing metacognitive capacity for self reflection in the psychotherapy for schizophrenia: A conceptual model of the key tasks and processes. *Psychology and Psychotherapy: Theory, Research and Practice, 84*(1), 58-69. doi: 10.1348/147608310x520436

Lysaker, P. H., Buck, K. D., & Ringer, J. (2007). The recovery of metacognitive capacity in schizophrenia across 32 months of individual psychotherapy: A case study. *Psychotherapy Research, 17*(6), 713-720. doi: 10.1080/10503300701255932

Lysaker, P. H., Carcione, A., Dimaggio, G., Johannesen, J. K., Nicolò, G., Procacci, M., et al. (2005). Metacognition amidst narratives of self and illness in schizophrenia: Associations with neurocognition, symptoms, insight and quality of life. *Acta Psychiatrica Scandinavica, 112*(1), 64-71. doi: 10.1111/j.1600-0447.2005.00514.x

Lysaker, P. H., Davis, L. W., Eckert, G. J., Strasburger, A. M., Hunter, N. L., & Buck, K. D. (2005). Changes in narrative structure and content in schizophrenia in long term individual psychotherapy: a single case study. *Clinical Psychology & Psychotherapy, 12*(5), 406-416. doi: 10.1002/cpp.457

Lysaker, P. H., Davis, L. W., Jones, A. M., Strasburger, A. M., & Beattie, N. L. (2007). Relationship and technique in the long-term integrative psychotherapy of schizophrenia: A single case study. *Counselling & Psychotherapy Research, 7*(2), 79-85.

Lysaker, P. H., Glynn, S. M., Wilkniss, S. M., & Silverstein, S. M. (2010). Psychotherapy and recovery from schizophrenia: A review of potential applications and need for future study. *Psychological Services, 7*(2), 75-91. doi: 10.1037/a0019115

Lysaker, P. H., & Gumley, A. (2010). Psychotherapeutic and relational processes and the development of metacognitive capacity following five years of individual psychotherapy: A case study of a person with psychotic symptoms. *Psychosis, 2*(1), 70-78. doi: 10.1080/17522430903026385

Lysaker, P. H., & Lysaker, J. T. (2002). Narrative structure in psychosis: Schizophrenia and disruptions in the dialogical self. *Theory Psychology, 12*(2), 207-220. doi: 10.1177/0959354302012002630

Lysaker, P. H., & Lysaker, J. T. (2006). A typology of narrative impoverishment in schizophrenia: Implications for understanding the processes of establishing and sustaining dialogue in individual psychotherapy. *Counselling Psychology Quarterly, 19*, 57-68. doi: 10.1080/09515070600673703

Lysaker, P. H., Lysaker, J. T., & Lysaker, J. T. (2001). Schizophrenia and the collapse of the dialogical self: Recovery, narrative and psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 38*(3), 252-261.

Martens, W. H. J. (2009). The role of self-complexity in reducing harmful insight among persons with schizophrenia. Theoretical and therapeutic implications. *American Journal of Psychotherapy, 63*(1), 53 - 68.

McLeod, J. (2004). Social construction, narrative and psychotherapy. In L. E. Angus & J. McLeod (Eds.), *The handbook of narrative and psychotherapy: Practice, theory and research* (pp. 351-366). California: Sage Publications, Inc.

Nelson, B., & Sass, L. A. (2009). Medusa's stare: A case study of working with self-disturbance in the early phase of schizophrenia. *Clinical Case Studies, 8*(6), 489-504. doi: 10.1177/1534650109351931

Nelson, B., Yung, A. R., Bechdolf, A., & McGorry, P. D. (2008). The phenomenological critique and self-disturbance: Implications for ultra-high risk ("prodrome") research. *Schizophrenia Bulletin, 34*(2), 381-392. doi: 10.1093/schbul/sbm094

Pote, H., Stratton, P., Cottrell, D., Shapiro, D., & Boston, P. (2003). Systemic family therapy can be manualized: research process and findings. *Journal of Family Therapy, 25*(3), 236-262. doi: 10.1111/1467-6427.00247

Roberts, G. A. (1991). Delusional belief systems and meaning in life: A preferred reality? . *British Journal of Psychiatry, 159*(14), 19-28.

Roberts, G. A. (2000). Narrative and severe mental illness: What place do stories have in an evidence-based world? *Advances in Psychiatric Treatment, 6*, 432-441.

Roe, D., & Ben-Yishai, A. (1999). Exploring the relationship between the person and the disorder among individuals hospitalized for psychosis. *Psychiatry, 62*(4), 370-380.

Safran, J. D., & Muran, J. C. (2000). Resolving therapeutic alliance ruptures: Diversity and integration. *Journal of Clinical Psychology, 56*(2), 233-243.

Sass, L. A., & Parnas, J. (2003). Schizophrenia, Consciousness, and the Self. *Schizophr Bull, 29*(3), 427-444.

Semerari, A., Carcione, A., Dimaggio, G., Falcone, M., Nicolò, G., Procacci, M., et al. (2003). How to evaluate metacognitive functioning in psychotherapy? The metacognition assessment scale and its applications. *Clinical Psychology & Psychotherapy, 10*(4), 238-261.

Stanghellini, G., & Lysaker, P. H. (2007). The psychotherapy of schizophrenia through the lens of phenomenology: Intersubjectivity and the search for the recovery of first- and second-person awareness. *American Journal of Psychotherapy, 61*, 163-179.

Vromans, L. P. (2007). *Process and outcome of narrative therapy for Major Depressive Disorder in adults: Narrative reflexivity, working alliance and improved symptom and inter-*

personal outcomes. Doctoral Dissertation, Queensland University of Technology, Brisbane.

Wasylenki, D. A. (1992). Psychotherapy of Schizophrenia Revisited. *Hosp Community Psychiatry, 43*(2), 123-127.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: W.W. Norton & Company.